

## ***Proposed Changes to Existing Measure for HEDIS<sup>®1</sup> MY 2026: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)***

NCQA seeks comments on proposed modifications to the HEDIS *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)* measure.

FUI assesses the percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder (SUD) among members 13 years of age or older that result in a follow-up visit or service for SUD. Two rates are reported:

- **Rate 1:** The percentage of discharges for which the member received follow-up for SUD within 30 days after the visit or discharge.
- **Rate 2:** The percentage of discharges for which the member received follow-up for SUD within 7 days after the visit or discharge.

The intent of this measure is to help ensure coordinated care for members with a SUD who are discharged from a high-intensity setting (e.g., residential treatment, inpatient hospitalization). To align with the intent and with NCQA's Continuity of Care measures, NCQA proposes the following revisions:

- **Allow an SUD diagnosis in any diagnosis position for all numerator events.** Stakeholders recommend allowing any diagnosis position on numerator claims to ensure that all substance use-related follow-up is captured in measure numerators. This change will also keep FUI in alignment with *Follow-Up After Emergency Department Visit for Substance Use (FUA)* and the recently re-evaluated *Follow-Up After Hospitalization for Mental Illness (FUH)* and *Follow-Up after Emergency Department Visit for Mental Illness (FUM)*, which currently allow a diagnosis in any position for the numerator event. This change will align all Continuity of Care measures.
- **Add peer support services as a follow-up option.** Stakeholders identified that peer support services, when incorporated into a care team, improve outcomes, especially in substance use populations. This change is also being explored to align FUI with FUA, FUM and FUH, and to expand the eligible workforce to be able to provide follow-up (given the shortage of behavioral health providers).
- **Remove pharmacotherapy dispensing events as follow-up.** Stakeholders identified that a pharmacy dispensing event of a medication for SUD does not indicate compliance with treatment or facilitate interaction with providers or ongoing treatment; thus, these numerator events may not align with the intent of follow-up or match the severity of the situation.

**Note:** *Methadone is not in the pharmacotherapy dispensing value sets (Alcohol Use Disorder Treatment Medication List and Opioid Use Disorder Treatment Medication List). Methadone treatment will be counted in the numerator of the measure through the medication treatment event value sets (AOD Medication Treatment Value Set and OUD Weekly Drug Treatment Service Value Set).*

Our expert panels support the proposed changes. NCQA seeks feedback on the following questions:

1. Do you agree with allowing an SUD diagnosis in any diagnosis position for all numerator events? If not, please describe why.
2. Do you agree with adding peer support services as a follow-up option? If not, please describe why.
3. Do you agree with removing pharmacotherapy dispensing events as follow-up? If not, please describe why.

Supporting documents include the current measure specifications, evidence workup and performance data.

**NCQA acknowledges the contributions of the Behavioral Health, Geriatric and Technical Measurement Advisory Panels.**

---

<sup>1</sup>HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

Measure title	Follow-Up After High-Intensity Care for Substance Use Disorder	Measure ID	FUI
<b>Description</b>	<p>The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among persons 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of visits or discharges for which the person received follow-up for substance use disorder within the 30 days after the visit or discharge.</li> <li>2. The percentage of visits or discharges for which the person received follow-up for substance use disorder within the 7 days after the visit or discharge.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement and rationale</b>	<p>Timely follow-up and continuity of care following a high-intensity event for a diagnosis of SUD is critical, as individuals receiving SUD care in these settings are vulnerable to losing contact with the health care system. Lack of timely follow-up can result in negative outcomes, such as continued substance use, relapse, high utilization of intensive care services and mortality. Although clinical practice guidelines and expert consensus do not define the ideal timing for follow-up, guidelines recommend that individuals with SUD receive patient-centered, timely follow-up care in an appropriate care setting, to ensure ongoing treatment and management.</p>		
<b>Citations</b>	<p>National Institute on Drug Abuse (NIDA). 2017. <i>Trends &amp; Statistics</i>. National Institute on Drug Abuse, April 2017. <a href="https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs">https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs</a></p> <p>National Institute on Drug Abuse (NIDA). 2018. <i>Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)</i>. National Institute on Drug Abuse, 17 Jan. 2018. <a href="https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition">https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition</a></p> <p>Work Group on Substance Use Disorders. 2006. <i>Practice Guideline for the Treatment of Patients With Substance Use Disorders Second Edition</i>. American Psychiatric Association (APA); Aug. 276 pg. [1789 references]. <a href="https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf">https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf</a></p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of date of the discharge, stay or event.</p> <ul style="list-style-type: none"> <li>• 13–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to the General Guideline: Data Collection Methods for additional information.</p> <p><b>Date specificity.</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance.</b> Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder and therefore is not included on medication lists. The <a href="#">AOD Medication Treatment Value Set</a> and <a href="#">OUD Weekly Drug Treatment Service Value Set</a> include codes that identify methadone treatment for opioid use disorder because these codes are used on medical claims, not on pharmacy claims.</p>
Definitions	
<b>Episode date</b>	<p>The date of service for any acute inpatient discharge, residential treatment discharge or withdrawal management visit with a principal diagnosis of SUD.</p> <p>For an acute inpatient discharge or residential treatment discharge or for withdrawal management that occurred during an acute inpatient stay or residential treatment stay, the episode date is the date of discharge.</p> <p>For direct transfers, the episode date is the discharge date from the transfer admission.</p> <p>For withdrawal management (other than withdrawal management that occurred during an acute inpatient stay or residential treatment stay), the episode date is the date of service.</p>

<p><b>Direct transfer</b></p>	<p>A direct transfer is when the discharge date from the first acute inpatient or residential care setting precedes the admission date to a second acute inpatient or residential care setting by one calendar day or less. For example:</p> <ul style="list-style-type: none"> <li>• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.</li> <li>• An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.</li> <li>• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.</li> </ul>
<p><b>Initial population</b></p>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical, chemical dependency and pharmacy. <b>Note:</b> A withdrawal management/detoxification-only chemical dependency benefit does not meet this criteria.</li> <li>• <i>Continuous enrollment:</i> Episode date through 30 days after the episode date (31 total days).</li> <li>• <i>Allowable gap:</i> None.</li> </ul> <p><i>Ages:</i> 13 years or older as of date of the discharge, stay or event.</p> <p><i>Event:</i></p> <p><b>Acute inpatient discharge, residential treatment or withdrawal management event for a principal diagnosis of substance use disorder from January 1–December 1 of the measurement period. Include all episodes.</b></p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• An acute inpatient discharge or a residential behavioral health stay with a principal diagnosis of substance use disorder (<u>AOD Abuse and Dependence Value Set</u>) on the discharge claim. To identify acute inpatient discharges:             <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays other than behavioral health (<u>Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> </li> <li>• A withdrawal management visit (<u>Detoxification Value Set</u>) <b>with</b> a principal diagnosis of substance use disorder (<u>AOD Abuse and Dependence Value Set</u>).</li> </ul> <p><b>Direct transfers</b></p> <p>Identify direct transfers to an acute inpatient care or residential setting. If the direct transfer to the acute inpatient or residential care setting was for a principal diagnosis of substance use disorder (<u>AOD Abuse and Dependence Value Set</u>), use the date of last discharge. Refer to the direct transfer definition above for examples.</p>

	<p>Use the following method to identify direct transfers:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays other than behavioral health (<u>Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set</u>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after December 1 of the measurement period.</p> <p>If the direct transfer to the acute inpatient or residential behavioral health care setting was for any other principal diagnosis, exclude both the original and the direct transfer discharge.</p> <p><b>Multiple discharges, visits or events in a 31-day period</b></p> <p>After evaluating for direct transfers, if a person has more than one episode in a 31-day period, include only the first eligible episode. For example, if a person is discharged from a residential treatment stay on January 1, include the January 1 discharge and do not include subsequent episodes that occur on or between January 2 and January 31; then, if applicable, include the next episode that occurs on or after February 1. Identify episodes chronologically, including only the first episode per 31-day period.</p> <p><i><b>Note:</b> Removal of multiple episodes in a 31-day period is based on eligibility. Assess each episode for eligibility before removing multiple episodes in a 31-day period.</i></p>
<p><b>Denominator exclusions</b></p>	<ul style="list-style-type: none"> <li>• <b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</li> <li>• <b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</li> </ul>
<p><b>Denominator</b></p>	<p>The initial population minus denominator exclusions</p>
<p><b>Numerator</b></p>	<p><b>Numerator 1- 30-Day Follow-Up</b></p> <p>A follow-up visit or event with any practitioner for a <del>principal</del> diagnosis of substance use disorder within the 30 days after an episode for substance use disorder.</p> <p><b>Numerator 2- 7-Day Follow-Up</b></p> <p>A follow-up visit or event with any practitioner for a <del>principal</del> diagnosis of substance use disorder within the 7 days after an episode for substance use disorder.</p> <p>For both indicators, any of the following meet criteria for a follow-up visit. Do not include visits that occur on the date of the denominator episode.</p>

- An acute or nonacute inpatient admission or residential behavioral health stay with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set) on the discharge claim. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An outpatient visit (BH Outpatient Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Nonresidential Substance Abuse Treatment Facility POS Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A substance use disorder service (Substance Use Disorder Services Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set)\* with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set)\*.
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- Residential behavioral health treatment (Residential Behavioral Health Treatment Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a ~~principal~~ diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).

	<ul style="list-style-type: none"> <li>• <a href="#">Peer support services (Peer Support Services Value Set) with a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).</a></li> <li>• A <a href="#">pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List)</a> or medication treatment event (<a href="#">AOD Medication Treatment Value Set</a>; <a href="#">OUD Weekly Drug Treatment Service Value Set</a>).</li> </ul> <p><b>Note:</b> Follow-up does not include withdrawal management. Exclude all withdrawal management events (<a href="#">Detoxification Value Set</a>) when identifying follow-up care for numerator compliance. Detoxification does not need to be excluded from pharmacotherapy dispensing events identified using pharmacy claims (<a href="#">Alcohol Use Disorder Treatment Medications List</a>; <a href="#">Opioid Use Disorder Treatment Medications List</a>), because detoxification codes are not used on pharmacy claims.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<p><b>Summary of changes</b></p>	<ul style="list-style-type: none"> <li>• Moved the direct transfer definition from the event/diagnosis section to the definitions section.</li> <li>• <a href="#">Removed the Opioid Use and Alcohol Use Disorder Treatment Medication List tables. This information is now found in the MLD.</a></li> <li>• <a href="#">Modified the numerators to allow a substance use disorder diagnosis to take any position on the claim.</a></li> <li>• <a href="#">Added peer support services to the numerators.</a></li> </ul>																												
<p><b>Data element tables</b></p>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table FUI-1/2/3: Data Elements for Follow-Up After High Intensity Care for Substance Use Disorder</b></p> <table border="1" data-bbox="488 1241 1466 1793"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp30Day</td> <td>13-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td rowspan="2">FollowUp7Day</td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>65+</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td rowspan="4"></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	FollowUp30Day	13-17	Benefit	Metadata	FollowUp7Day	18-64	InitialPopulation	For each Stratification, repeat per Metric	65+	Exclusions	For each Stratification, repeat per Metric		Total	Denominator	For each Stratification, repeat per Metric		NumeratorByAdmin	For each Metric and Stratification		NumeratorBySupplemental	For each Metric and Stratification		Rate	(Percent)
Metric	Age	Data Element	Reporting Instructions																										
FollowUp30Day	13-17	Benefit	Metadata																										
FollowUp7Day	18-64	InitialPopulation	For each Stratification, repeat per Metric																										
	65+	Exclusions	For each Stratification, repeat per Metric																										
	Total	Denominator	For each Stratification, repeat per Metric																										
		NumeratorByAdmin	For each Metric and Stratification																										
		NumeratorBySupplemental	For each Metric and Stratification																										
		Rate	(Percent)																										

## ***Follow-Up After High Intensity Care for Substance Use Disorder (FUI)*** **Measure Workup**

### **Topic Overview**

In 2022, 48.7 million U.S. residents 12 years of age and older (17.3% of the population) were classified as having a substance use disorder (SUD) within the past year (SAMHSA, 2022). SUDs are a significant contributor to morbidity and mortality in the United States and cost the health care system billions of dollars per year in direct and indirect expenditures. Although evidence supports follow-up care after “high intensity” treatment for a SUD (e.g., inpatient hospitalization, medically managed withdrawal/detoxification, residential treatment visit or stay) to reduce negative health outcomes, few individuals receive appropriate follow-up care (SAMHSA, 2022; Cole et al., 2022; Acevedo et al., 2018; Rubinsky et al., 2018).

### **Prevalence and Importance**

SUD is defined as when recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability and failure to meet major responsibilities at work, school or home. (SAMHSA, 2023). Commonly abused substances include alcohol and marijuana, cocaine, methamphetamine, nonprescription opioids and stimulants (SAMHSA, 2017). SUDs can be mild, moderate or severe, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (SAMHSA, 2015).

According to the National Survey on Drug Use and Health (NSDUH), the number of Americans classified with an SUD increased from 2002–2022 (20.6 million–48.7 million) (SAMHSA, 2015; SAMHSA 2022). In 2022, 29.5 million individuals 12 and older reported an alcohol use disorder, and 27.2 million reported an illicit drug use disorder (SAMHSA, 2022). An estimated 8 million individuals with an SUD reported both alcohol use and illicit drug use disorders within the past year (SAMHSA, 2022).

SUD-related mortality and overdose rates have risen significantly in the past decade (Spencer, 2024). The age-adjusted rate of drug overdose deaths increased from 8.2 deaths per 100,000 in 2002, to 32.6 in 2022 (Spencer, 2024). Today in the U.S., drug overdose is the leading cause of injury, and an estimated 10% of deaths among working adults are due to excessive drinking (CDC, 2017; Stahre et al., 2014).

Individuals with SUD have higher utilization of high-intensity care setting treatment, such as inpatient hospitalizations. The National Survey on Drug Use and Health (NSDUH) data from 2009–2013 indicate that people with SUDs have higher rates of all-cause hospitalization than those without SUDs (Gryczynski et al., 2016). In 2019, the number of SUD treatment admissions per 10,000 was 65.9 (Cantor 2022). In 2021, alcohol-related disorders and opioid-related disorders accounted for 22.18% and 11.51% of readmissions within 30 days for any cause in the Medicaid population, respectively (HCUPnet Data Tools).

#### **Health importance**

SUDs pose significant health risks that necessitate a comprehensive understanding and approach to treatment. Individuals with SUD are at increased risk of overdose, injury, soft tissue infections and mortality (Bahorik, A.L, 2017). Consequently, addressing these risks is critical. The primary goals of alcohol and drug abuse or dependence treatment are abstinence, relapse prevention, rehabilitation and recovery (NIDA, 2018a).

Research supports the need for individuals with SUD to not only receive timely follow-up care following treatment in a high-intensity care setting (e.g. hospitalization, medically managed withdrawal/detoxification, residential treatment visit), but also to stabilize or cease using the substance(s) and engage in ongoing treatment to prevent relapse (NIDA, 2018a; Proctor & Herschman, 2014; McKay, 2021). Individuals who receive timely follow-up care



may be more likely to complete treatment or receive more days of treatment than those who do not receive follow-up care (Proctor & Herschman, 2014).

### **Financial importance and cost-effectiveness**

Total overall costs of substance misuse and SUDs in the U.S., including loss of work productivity, direct health care expenditures and crime-related costs, exceed \$700B annually (NIDA, 2020). One study estimated that the hospital costs for treating SUD are \$13.2B annually (Peterson et al., 2021). Another study modeled commercial health insurance costs for SUD and found that the attributable medical expenditure each year was over \$15,000 per enrollee with an SUD diagnosis (Li et al., 2023). Conservative estimates suggest that for every dollar invested in addiction treatment programs, between \$4 and \$7 are directly returned in decreased drug-related crime, criminal justice costs and theft (NIDA, 2018b).

## **Opportunities for Improvement**

### **Potential for Improvement**

Studies have found that timely follow-up after treatment in an intensive care setting for SUD is an effective method for improving patient outcomes, reducing health care utilization and decreasing the overall cost of care for patients with SUD. Patients can receive needed services to help manage their condition and reduce the likelihood of relapse, readmissions and utilization of other intensive services (Lee et al., 2014; VA/DoD, 2015; NIDA, 2018a; Reif, 2017).

#### **Gaps in care**

Despite the high prevalence of SUDs, only a portion of those in need of services receive them. SAMHSA found that only 24% of people classified as needing treatment for substance use (with or without an SUD diagnosis) received treatment (2022), and only 14.9% of those who had been formally diagnosed with an SUD in the past year received treatment. Findings also indicated that people who had a higher acuity SUD were less likely to receive treatment than those with a mild SUD.

A study of Medicaid enrollees with opioid use disorder (OUD) in 10 states found that 62.5% of enrollees did not receive a follow-up visit or medications for opioid use disorder (MOUD) within 7 days of discharge from residential treatment. Additionally, 46.9% did not have a follow-up visit or receive MOUD within 30 days of discharge (Cole et al., 2022). The literature also indicates significant variability in follow-up rates across programs and agencies (Acevedo et al., 2018; Rubinsky et al., 2018).

SAMHSA survey data of individuals 12 years and older indicate common reasons for not receiving treatment for an SUD (2022). 47.9% of respondents thought treatment would cost too much; 41.9% did not have health insurance coverage for treatment. An additional 37.7% reported that insurance would not pay enough of the related costs of treatment. 52.2% did not know where or how to get treatment. 61.3% were not ready to start treatment, and 52.9% were not ready to stop or cut back on using drugs. 24.2% reported that they had problems with activities such as transportation, childcare or getting convenient appointment times.

#### **Health care disparities**

Several patient characteristics are associated with an increased prevalence and risk of SUDs, including age, gender, ethnicity/race and geography. In 2022, SAMHSA reported that 24% of American Indian or Alaska Native individuals were affected by substance abuse or dependence, compared with

9.0% of Asian Americans. Research has shown that American Indians/Alaska Natives are at a higher risk of alcohol and opioid-related deaths and overdoses (Karaye et al., 2023; Oluwoye et al., 2020; White et al., 2020).

Studies suggest that women suffer greater harms than men from alcohol-induced hangovers, liver inflammation, cardiovascular diseases and infant death (CDC ARDI, 2024; White, 2020; van Lawick van Pabst et al., 2019; Vatsalya et al., 2018; Kirpich et al., 2017).

From 1999–2019, drug overdose death rates in the U.S. fluctuated, initially higher in urban areas, then higher in rural areas from 2007–2015 and again higher in urban areas by 2019, with specific drug types showing varied patterns between urban and rural regions (Hedegaard & Spencer, 2021). Unemployment has also been associated with a higher risk and prevalence of SUDs (SAMHSA, 2022).

Reports reveal differences in receiving OUD treatment based on race/ethnicity, age, employment status and geography. A CDC report indicates that higher percentages of non-Hispanic White adults received OUD treatment (60.3%) than non-Hispanic Black or African American (43.8%) and Hispanic or Latino (45.7%) adults. Adults 50 or older, and those who are unemployed, have lower rates of receiving OUD treatment (Dowell et al., 2024).

Studies suggest that individuals in rural areas are less likely to receive treatment for SUDs or alcohol-related concerns than those in urban or suburban areas (Davis & O'Neill, 2022; Ali et al., 2022; Abraham & Yarbrough, 2021; Edmonds et al., 2021). A SAMHSA trends report notes that the admission rate in the South is consistently the lowest, compared to the other three regions in the U.S. (2022).

**Peer support services**

In 2022, the NSDUH reported that 3.4% of individuals received services for substance use, including support groups, peer support specialists or recovery coaches, ER visits and detoxification or withdrawal support. Two million people (0.7%) received assistance from a peer support specialist or recovery coach.

While peers may not be able to provide clinical care, they can provide alternative services such as advocacy and care linkage and can strengthen engagement in care. In a pilot project conducted by SAMHSA, people in crisis who were referred to peers showed a decrease in inpatient days, an increase in outpatient visits, reduced re-admission rate and an overall decrease in total costs related to behavioral health (Hajny et al., 2015). Additional studies found that peer support services in populations with SUD are associated with lower rates of relapse and homelessness, and higher rates of abstinence (Boisvert et al., 2008; Tracy & Wallace, 2016).

**Guideline recommendations**

Key stakeholder groups such as the American Society of Addiction Medicine (ASAM, 2015), the Substance Abuse and Mental Health Services Administration (SAMHSA, 2015), the National Institute on Drug Addiction (NIDA, 2018), the Veteran Affairs/Department of Defense (Management of Substance use Disorders Work Group, 2015) and the American Psychiatric Association (Work Group on Substance Use Disorders, 2006) have all issued guidelines and recommendations on the treatment of SUDs. Existing guidelines for SUD treatment target drug of choice, age range and other

factors such as pregnancy or justice involvement. Overall, guidelines suggest that clinicians should ensure that treatment plans are personalized and frequently reassessed to maintain effectiveness and safety, and to reduce the risk of relapse. The guidelines support services that continue care after discharge from inpatient and other high-intensity settings and ensure timely access to care.

## References

- Abraham, A.J., & C.R. Yarbrough. 2021. "Availability of Medications for the Treatment of Alcohol Use Disorder in U.S. Counties, 2016–2019." *Journal of Studies on Alcohol and Drugs* 82(6), 689–99.
- Acevedo, A., M.T. Lee, D.W. Garnick, C.M. Horgan, G.A. Ritter, L. Panas, K. Campbell, & J. Bean-Mortinson. 2018. "Agency-Level Financial Incentives and Electronic Reminders to Improve Continuity of Care After Discharge From Residential Treatment and Detoxification\*." *Drug and Alcohol Dependence* 183, 192–200. <https://doi.org/10.1016/j.drugalcdep.2017.11.009>
- Ali, M.M., E. Nye, & K. West. 2022. "Substance Use Disorder Treatment, Perceived Need for Treatment, and Barriers to Treatment Among Parenting Women With Substance Use Disorder in US Rural Counties." *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association* 38(1), 70–6. <https://doi.org/10.1111/jrh.12488>
- American Society of Addiction Medicine (ASAM). 2014. *The ASAM Criteria*. Third Edition. <http://www.asamcriteria.org/>
- Bahorik, A.L., D.D. Satre, A.H. Kline-Simon, C.M. Weisner, C.L. Campbell. 2017. "Alcohol, Cannabis, and Opioid Use Disorders, and Disease Burden in an Integrated Health Care System." *J Addiction Medicine* 11(1):3–9.
- Boisvert, R.A., L.M. Martin, M. Grosek, & A.J. Clarie. 2008. "Effectiveness of a Peer-Support Community in Addiction Recovery: Participation as Intervention." *Occupational Therapy International* 15(4), 205–20. <https://doi.org/10.1002/oti.257>
- Centers for Disease Control and Prevention. 2024. *Alcohol Related Disease Impact (ARDI) Application, 2024*. [www.cdc.gov/ARDI](http://www.cdc.gov/ARDI)
- Cole, E.S., L. Allen, A. Austin, A. Barnes, C.-C.H. Chang, S. Clark, D. Crane, P. Cunningham, C.E. Fry, A.J. Gordon, L. Hammerslag, D. Idala, S. Kennedy, J.Y. Kim, S. Krishnan, P. Lanier, S. Mahakalanda, R. Mauk, M.J. McDuffie, ... J.M. Donohue. 2022. "Outpatient Follow-Up and Use of Medications for Opioid Use Disorder After Residential Treatment Among Medicaid Enrollees in 10 States." *Drug and Alcohol Dependence* 241, 109670. <https://doi.org/10.1016/j.drugalcdep.2022.109670>
- Davis, C.N., & S.E. O'Neill. 2022. "Treatment of Alcohol Use Problems Among Rural Populations: A Review of Barriers and Considerations for Increasing Access to Quality Care." *Current Addiction Reports* 9(4), 432–444. <https://doi.org/10.1007/s40429-022-00454-3>
- Dowell, D., S. Brown, S. Gyawali, et al. 2024. "Treatment for Opioid Use Disorder: Population Estimates — United States, 2022." *MMWR* 73:567–74. DOI: <http://dx.doi.org/10.15585/mmwr.mm7325a1>
- Edmonds, A.T., K.M. Bensley, E.J. Hawkins, & E.C. Williams. 2021. "Geographic Differences in Receipt of Addictions Treatment in a National Sample of Patients with Alcohol use Disorders from the U.S. Veterans Health Administration." *Substance Abuse* 42(4), 559–68. <https://doi.org/10.1080/08897077.2020.1803176>
- Gryczynski, J., R. Schwartz, et al. 2016. "Understanding Patterns Of High-Cost Health Care Use Across Different Substance User Groups." *Health Aff (Millwood)*. January; 35(1): 12–19.
- Hajny, J., S. Miccio, S. Bergeson, H. Rae, & P. Lyons. 2015. "Peer as Crisis Service Providers." PowerPoint slides. The National Coalition for Mental Health Recovery. [https://www.nasmhpd.org/sites/default/files/Peers%20as%20Crisis%20Service%20Providers\\_SAMSHA\\_6.10.15.pdf](https://www.nasmhpd.org/sites/default/files/Peers%20as%20Crisis%20Service%20Providers_SAMSHA_6.10.15.pdf)
- HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. <https://datatools.ahrq.gov/hcupnet>
- Hedegaard, H., & M.R. Spencer. (n.d.). *Urban–Rural Differences in Drug Overdose Death Rates, 1999–2019*. Retrieved July 5, 2024, from <https://stacks.cdc.gov/view/cdc/102891>

- Karaye, I.M., N. Maleki, & I. Yunusa. 2023. "Racial and Ethnic Disparities in Alcohol-Attributed Deaths in the United States, 1999–2020." *International Journal of Environmental Research and Public Health* 20(8), Article 8. <https://doi.org/10.3390/ijerph20085587>
- Kirpich, I.A., C.J. McClain, V. Vatsalya, M. Schwandt, M. Phillips, K.C. Falkner, L. Zhang, C. Harwell, D.T. George, & J.C. Umhau. 2017. "Liver Injury and Endotoxemia in Male and Female Alcohol-dependent Individuals Admitted to an Alcohol Treatment Program." *Alcoholism, Clinical and Experimental Research* 41(4), 747–57. <https://doi.org/10.1111/acer.13346>
- Li, M., C. Peterson, L. Xu, C.A. Mikosz, & F. Luo. 2023. "Medical Costs of Substance Use Disorders in the US Employer-Sponsored Insurance Population." *JAMA Network Open* 6(1), e2252378. <https://doi.org/10.1001/jamanetworkopen.2022.52378>
- Management of Substance Use Disorders Work Group. 2015. *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*. Version 3.0. December 2015. Washington (DC): Department of Veterans Affairs, Department of Defense. 169 p. [327 references]. <https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf>
- McKay, J.R. 2021. "Impact of Continuing Care on Recovery From Substance Use Disorder." *Alcohol Research : Current Reviews* 41(1), 01. <https://doi.org/10.35946/arcr.v41.1.01>
- National Institute on Drug Abuse (NIDA). 2018a. *Drugs, Brains, and Behavior: The Science of Addiction*. July 2018. Retrieved from <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>.
- NIDA. 2018b. *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*. January 17, 2018. <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>
- NIDA. 2020. *Trends & Statistics*. National Institute on Drug Abuse. <https://nida.nih.gov/research-topics/trends-statistics>
- Oluwoye, O., L.S. Kriegel, K.C. Alcover, K. Hirschak, & S. Amiri. 2020. "Racial and Ethnic Differences in Alcohol-, Opioid-, and Co-Use-Related Deaths in Washington State from 2011 to 2017." *Addictive Behaviors Reports* 12, 100316. <https://doi.org/10.1016/j.abrep.2020.100316>
- Peterson, C., M. Li, L. Xu, C.A. Mikosz, & F. Luo. 2021. "Assessment of Annual Cost of Substance Use Disorder in US Hospitals." *JAMA Network Open* 4(3), e210242. <https://doi.org/10.1001/jamanetworkopen.2021.0242>
- Proctor, S., P. Herschman. 2014. "The Continuing Care Model of Substance Use Treatment: What Works, and When Is 'Enough,' Enough?" *Psychiatry Journal*, Volume 2014, Article ID 692423, 16 pages.
- Rubinsky, A.D., L.S. Ellerbe, S. Gupta, T.E. Phelps, T. Bowe, J.L. Burden, & A.H.S. Harris. 2018. "Outpatient Continuing Care After Residential Substance Use Disorder Treatment in the US Veterans Health Administration: Facilitators and Challenges." *Substance Abuse* 39(3), 322–30. <https://doi.org/10.1080/08897077.2017.1391923>
- SAMHSA. 2015. *Federal Guidelines for Opioid Treatment Programs*. HHS Publication No. HSS28320070053I/HHSS28342003T. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. <https://library.samhsa.gov/sites/default/files/guidelines-opioid-treatment-pep15-fedguideotp.pdf>
- SAMHSA. 2016. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*. HHS Publication No. SMA 16-4984, NSDUH Series H-51. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015Rev1/NSDUH-FFR1-2015Rev1/NSDUH-FFR1-2015Rev1/NSDUH-National%20Findings-REVISED-2015.pdf>
- SAMHSA. 2017. *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*. HHS Publication No. SMA 17-5044, NSDUH Series H-52. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>
- SAMHSA, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2020. Admissions to and Discharges from Publicly Funded Substance Use Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022.

- SAMHSA. 2022. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*. HHS Publication No. PEP23-07-01-006, NSDUH Series H-58. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report>
- SAMHSA. 2023. *Mental Health and Substance Use Disorders*. <https://www.samhsa.gov/find-help/disorders>
- Spencer, M.R., M.F. Garnett, and A.M. Minino. 2024. “Drug Overdose Deaths in the United States, 2002-2022.” National Center for Health Statistics. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/products/databriefs/db491.htm#:~:text=Age%2Dadjusted%20rates%20of%20drug%20overdose%20deaths%20involving%20synthetic%20opioids,around%202011%20continued%20through%202022.>
- Stahre, M., J. Roeber, D. Kanny, R.D. Brewer, X. Zhang. 2014. “Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States.” *Prev Chronic Dis* 11:130293. DOI: <http://dx.doi.org/10.5888/pcd11.130293>
- K., Tracy, S.P. Wallace. 2016. “Benefits of Peer Support Groups in the Treatment of Addiction.” *Subst Abuse Rehabil* 7:143–54. <https://doi.org/10.2147/SAR.S81535>.
- Van Lawick van Pabst, A.E., L.E. Devenney, & J.C. Verster. 2019. “Sex Differences in the Presence and Severity of Alcohol Hangover Symptoms.” *Journal of Clinical Medicine* 8(6), 867. <https://doi.org/10.3390/jcm8060867>
- Vatsalya, V., B.L. Stangl, V.Y. Schmidt, & V.A. Ramchandani. 2018. “Characterization of Hangover following Intravenous Alcohol Exposure in Social Drinkers: Methodological and Clinical Implications.” *Addiction Biology* 23(1), 493–502. <https://doi.org/10.1111/adb.12469>
- White, A.M. 2020. “Gender Differences in the Epidemiology of Alcohol Use and Related Harms in the United States.” *Alcohol Research: Current Reviews* 40(2), 01. <https://doi.org/10.35946/arcr.v40.2.01>
- White, A.M., I.-J.P. Castle, R.W. Hingson, & P.A. Powell. 2020. “Using Death Certificates to Explore Changes in Alcohol-Related Mortality in the United States, 1999 to 2017.” *Alcoholism, Clinical and Experimental Research* 44(1), 178–87. <https://doi.org/10.1111/acer.14239>
- Work Group on Substance Use Disorders. 2006. *Practice Guideline for the Treatment of Patients With Substance Use Disorders Second Edition*. American Psychiatric Association (APA); 2006 Aug. 276 pg. [1789 references]. [https://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/substanceuse.pdf](https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf)

## HEDIS Health Plan Performance Rates: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

### Commercial Results: Tables 1–8

**Table 1. HEDIS FUI Measure Performance—Commercial Plans (30 Day Rate: Total, All Ages)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	266 (63.3)	62.8	8.7	51.5	57.9	63.0	68.4	73.5
2022	417	277 (66.4)	62.5	8.8	50.8	58.2	62.8	67.7	73.6
2021	419	285 (68.0)	63.7	8.0	53.1	59.0	64.1	68.7	73.5

\*For 2023 the average denominator across plans was 298 individuals, with a standard deviation of 391.

**Table 2. HEDIS FUI Measure Performance—Commercial Plans (30 Day Rate: 13–17 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	3 (0.7)	65.6	23.6	45.0	45.0	60.4	91.4	91.4
2022	417	5 (1.2)	60.6	13.6	50.0	52.5	55.8	60.6	83.9
2021	419	4 (1.0)	57.0	18.2	38.7	42.9	54.5	71.1	80.3

\*For 2023 the average denominator across plans was 75 individuals, with a standard deviation of 30.

**Table 3. HEDIS FUI Measure Performance—Commercial Plans (30 Day Rate: 18–64 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	263 (62.6)	63.2	8.5	51.8	58.0	63.3	68.9	73.7
2022	417	274 (65.7)	62.8	8.9	51.1	58.4	63.2	68.3	74.0
2021	419	279 (66.6)	64.3	8.1	53.5	59.6	64.5	69.7	74.2

\*For 2023 the average denominator across plans was 292 individuals, with a standard deviation of 378.

**Table 4. HEDIS FUI Measure Performance—Commercial Plans (30 Day Rate: 65+ Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	4 (1.0)	51.2	13.2	37.8	42.6	48.8	59.7	69.4
2022	417	6 (1.4)	43.7	21.9	18.2	27.5	39.2	67.3	70.6
2021	419	3 (0.7)	48.2	31.0	26.5	26.5	34.4	83.7	83.7

\*For 2023 the average denominator across plans was 45 individuals, with a standard deviation of 13.

**Table 5. HEDIS FUI Measure Performance—Commercial Plans (7 Day Rate: Total, All Ages)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	266 (63.3)	44.6	10.5	30.4	38.1	44.5	51.1	57.6
2022	417	277 (66.4)	44.3	10.6	29.9	37.7	44.1	50.2	58.3
2021	419	285 (68.0)	45.0	10.4	32.1	38.2	45.3	51.8	57.5

\*For 2023 the average denominator across plans was 298 individuals, with a standard deviation of 391.

**Table 6. HEDIS FUI Measure Performance—Commercial Plans (7 Day Rate: 13–17 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	3 (0.7)	48.4	21.7	32.5	32.5	39.6	73.1	73.1
2022	417	5 (1.2)	38.1	11.3	26.5	29.5	39.4	40.0	55.2
2021	419	4 (1.0)	43.7	18.7	19.6	29.2	46.7	58.3	61.7

\*For 2023 the average denominator across plans was 75 individuals, with a standard deviation of 30.

**Table 7. HEDIS FUI Measure Performance—Commercial Plans (7 Day Rate: 18–64 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	263 (62.6)	44.8	10.3	31.3	38.0	44.6	51.5	57.5
2022	417	274 (65.7)	44.8	10.7	30.6	38.2	44.6	50.5	59.4
2021	419	279 (66.6)	45.7	10.6	32.3	38.9	45.6	52.5	59.3

\*For 2023 the average denominator across plans was 292 individuals, with a standard deviation of 378.

**Table 8. HEDIS FUI Measure Performance—Commercial Plans (7 Day Rate: 65+ Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	4 (1.0)	28.3	15.2	12.5	17.4	26.1	39.2	48.4
2022	417	6 (1.4)	29.8	17.9	12.5	15.2	24.5	49.1	52.9
2021	419	3 (0.7)	26.5	24.8	11.8	11.8	12.5	55.1	55.1

\*For 2023 the average denominator across plans was 45 individuals, with a standard deviation of 13.

## Medicaid Results: Tables 9–16

**Table 9. HEDIS FUI Measure Performance—Medicaid Plans (30 Day Rate: Total, All Ages)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	187 (67.3)	51.8	14.4	31.7	40.1	53.3	63.7	69.8
2022	272	177 (65.1)	49.8	14.6	30.9	38.3	50.8	61.2	68.7
2021	270	165 (61.1)	49.1	15.1	27.7	37.8	52.5	60.7	69.6

\*For 2023 the average denominator across plans was 1,592 individuals, with a standard deviation of 2,312.



**Table 10. HEDIS FUI Measure Performance—Medicaid Plans (30 Day Rate: 13–17 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	20 (7.2)	37.7	20.2	12.9	22.6	31.5	54.4	66.2
2022	272	15 (5.5)	49.0	21.4	18.8	26.2	56.4	64.3	73.0
2021	270	16 (5.9)	42.1	19.3	20.2	25.4	39.4	56.2	72.5

\*For 2023 the average denominator across plans was 85 individuals, with a standard deviation of 62.

**Table 11. HEDIS FUI Measure Performance—Medicaid Plans (30 Day Rate: 18–64 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	185 (66.5)	52.3	14.2	33.0	41.1	53.7	63.8	69.9
2022	272	176 (64.7)	50.0	14.6	31.8	38.8	51.1	61.7	68.8
2021	270	164 (60.7)	49.5	14.9	29.0	38.3	52.9	60.9	69.8

\*For 2023 the average denominator across plans was 1,582 individuals, with a standard deviation of 2,303.

**Table 12. HEDIS FUI Measure Performance—Medicaid Plans (30 Day Rate: 65+ Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	29 (10.4)	45.6	12.2	26.4	37.7	47.4	53.9	60.0
2022	272	20 (7.4)	42.4	13.3	31.2	32.1	42.2	52.1	58.0
2021	270	15 (5.6)	37.9	16.7	10.0	30.0	39.5	52.4	56.4

\*For 2023 the average denominator across plans was 52 individuals, with a standard deviation of 17.

**Table 13. HEDIS FUI Measure Performance—Medicaid Plans (7 Day Rate: Total, All Ages)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	189 (68.0)	32.8	12.8	15.9	23.1	32.3	41.5	50.8
2022	272	178 (65.4)	31.0	12.8	15.2	20.8	30.0	40.4	49.6
2021	270	168 (62.2)	30.4	13.4	13.3	18.8	28.9	40.2	49.4

\*For 2023 the average denominator across plans was 1,578 individuals, with a standard deviation of 2,304.

**Table 14. HEDIS FUI Measure Performance—Medicaid Plans (7 Day Rate: 13–17 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	20 (7.2)	22.3	15.7	4.7	10.2	15.8	36.4	45.6
2022	272	15 (5.5)	33.1	23.3	4.7	9.5	30.6	39.3	68.2
2021	270	16 (5.9)	25.8	13.4	11.8	14.8	22.8	32.8	46.8

\*For 2023 the average denominator across plans was 85 individuals, with a standard deviation of 62.

**Table 15. HEDIS FUI Measure Performance—Medicaid Plans (7 Day Rate: 18–64 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	187 (67.3)	33.3	12.8	16.1	24.1	33.0	42.4	50.9
2022	272	177 (65.1)	31.0	12.8	15.4	21.2	30.1	39.8	50.0
2021	270	167 (61.9)	30.6	13.4	12.6	19.4	29.2	40.0	49.5

\*For 2023 the average denominator across plans was 1,568 individuals, with a standard deviation of 2,294.

**Table 16. HEDIS FUI Measure Performance—Medicaid Plans (7 Day Rate: 65+ Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	29 (10.4)	26.5	8.2	14.5	22.2	27.3	31.6	38.1
2022	272	20 (7.4)	25.1	8.9	15.1	17.1	23.3	33.3	37.2
2021	270	15 (5.6)	25.2	13.1	7.3	13.6	26.0	39.5	42.9

\*For 2023 the average denominator across plans was 52 individuals, with a standard deviation of 17.

## Medicare Results Tables 17–22

**Table 17. HEDIS FUI Measure Performance—Medicare Plans (30 Day Rate: Total, All Ages)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	215 (28.3)	39.7	12.2	23.7	32.2	38.8	46.8	55.9
2022	750	214 (28.5)	39.1	11.8	25.0	30.9	37.9	46.2	54.1
2021	714	153 (21.4)	40.4	12.6	25.3	31.6	39.5	47.6	59.5

\*For 2023 the average denominator across plans was 189 individuals, with a standard deviation of 298.

**Table 18. HEDIS FUI Measure Performance—Medicare Plans (30 Day Rate: 18–64 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	144 (18.9)	43.4	13.1	27.6	34.3	42.9	50.7	60.4
2022	750	144 (19.2)	42.1	13.0	24.2	33.2	42.2	50.7	59.8
2021	714	97 (13.6)	42.3	13.5	24.4	31.6	42.9	50.0	59.3

\*For 2023 the average denominator across plans was 152 individuals, with a standard deviation of 209.

**Table 19. HEDIS FUI Measure Performance—Medicare Plans (30 Day Rate: 65+ Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	135 (17.8)	34.8	11.9	21.1	26.7	33.3	42.2	50.8
2022	750	129 (17.2)	34.2	11.6	19.5	26.0	33.5	40.5	49.5
2021	714	75 (10.5)	36.0	10.2	24.1	29.4	35.5	41.1	50.0

\*For 2023 the average denominator across plans was 119 individuals, with a standard deviation of 156.

**Table 20. HEDIS FUI Measure Performance—Medicare Plans (7 Day Rate: Total, All Ages)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	215 (28.3)	21.2	10.1	10.3	13.6	19.6	26.6	33.3
2022	750	214 (28.5)	20.9	9.4	10.9	14.5	19.5	25.0	32.3
2021	714	153 (21.4)	21.1	10.0	9.7	14.6	19.5	25.8	34.7

\*For 2023 the average denominator across plans was 189 individuals, with a standard deviation of 298.

**Table 21. HEDIS FUI Measure Performance—Medicare Plans (7 Day Rate: 18–64 Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	144 (18.9)	24.5	10.5	11.6	17.1	23.7	31.2	37.2
2022	750	144 (19.2)	24.1	10.8	10.8	16.7	23.0	29.7	36.7
2021	714	97 (13.6)	23.1	11.2	9.8	15.3	21.3	27.9	40.0

\*For 2023 the average denominator across plans was 152 individuals, with a standard deviation of 209.

**Table 22. HEDIS FUI Measure Performance—Medicare Plans (7 Day Rate: 65+ Years)**

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	135 (17.8)	17.7	9.0	8.5	11.9	15.9	21.7	29.6
2022	750	129 (17.2)	17.3	8.5	8.2	11.9	16.5	21.1	26.7
2021	714	75 (10.5)	17.7	8.2	8.9	12.2	16.7	21.1	29.4

\*For 2023 the average denominator across plans was 119 individuals, with a standard deviation of 156.